STATE OF MARYLAND

Request for Proposals
Point-of-Service (POS) Plans

Solicitation No. F10R9000121

Department of Budget and Management
Employee Benefits Division
March 30, 1999

NOTICE

Prospective offerors who have received this document from a source other than the Issuing Office should immediately contact the Issuing Office and provide their name and mailing address so that the amendments to the RFP or other communications can be sent to them

Minority Businesses are Encouraged to Respond to this Solicitation

NOTICE TO OFFERORS

In order to help us improve the quality of State proposal solicitations, and to make our procurement process more responsive and Abusiness friendly@, we ask that you take a few minutes and provide comments and suggestions regarding the enclosed solicitation. Please return your comments with your proposal. If you have chosen not to bid on this contract, please fax this completed form to: (**410 333-7122**).

Proposal Number: **Solicitation No. F10R9000121**
Entitled: **Point-of-Service (POS) Plans**
Date: **March 30, 1999**

1. If you have responded with a Ano bid@, please indicate the reason(s) below:

R Other commitments preclude our participation at this time.

R The subject of the solicitation is not something we ordinarily provide.

R We are inexperienced in the work required.

R Specifications are unclear, too restrictive, etc. (please explain in the Remarks section).

R The scope of work is beyond our present capacity.

R Doing business with State of Maryland Government is simply too complicated (please explain in the Remarks section).

R We cannot be competitive (please explain in the Remarks section).

R Time allotted for completion of the proposal is insufficient.

R Start-up/implementation time is insufficient.

R Proposal requirements (other than specifications) are unreasonable or too risky (please explain in the Remarks section).

R MBE requirements (please explain in the Remarks section).

R Prior State of Maryland contract experience was unprofitable or otherwise unsatisfactory (please explain in the Remarks section).

R Payment schedule is too slow.

Other:_____

2. If you have submitted a proposal, but wish to offer suggestions or express concerns, please use the Remarks section below (use reverse or attach additional pages as needed).

REMARKS:_____

Vendor Name:_____ Date:_____

Contact Person:_____ Phone:_____

Address:_____

PROCUREMENT SCHEDULE

Point-of-Service (POS) Plans

March 30, 1999	Advertisement of the Request for Proposals for Point-of-Service (POS) Plans
March 30, 1999	Issuance of Request for Proposals
April 13, 1999	Closing date for receipt of written questions to be answered during the pre-proposal conference. Must be received at the Issuing Office by 10:00 a.m. local time.
April 19, 1999	Pre-proposal Conference at 1:00 p.m. 300 West Preston Street - 1st floor auditorium Baltimore, MD 21201
May 6, 1999	Closing date for submission of proposals. Proposals must be received at the Issuing Office by 1:00 p.m.

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SECTION 1. GENERAL INFORMATION

1.1 SUMMARY STATEMENT

The Department of Budget and Management is issuing this Request for Proposals (RFP) to obtain no more than three (3) Point-of-Service (POS) vendors to provide health insurance benefits for state members and their dependents. The State=s goal is to offer a full complement of benefits in order to attract and retain valued employees as well as ensure their long term well-being.

1.2 DEFINITIONS

For the purposes of this RFP, the following terms have the meanings indicated below:

ACOB@ means Coordination of Benefits.

ACOBRA@ means Consolidated Omnibus Budget Reconciliation Act.

ACOMAR@ means Code of Maryland Regulations.

AContractual Employee@ means a non-permanent employee of the State of Maryland who is not eligible for State subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program, paying full premium costs.

ACovered Lives@ means each individual enrolled in a plan.

ADBM@ means the Department of Budget and Management.

ADependent@ means a spouse, natural child, step-child, legally adopted child, or legal ward of an eligible member, as defined in COMAR 06.01.07.03A(11).

ADirect Pay Enrollee@ means an individual who is billed directly by the

Department of Budget and Management for selected benefits.

AEBD@ means Employee Benefits Division.

AEOB@ means Explanation of Benefits.

AFTE@ means Full-Time Equivalent.

ALeave of Absence@ means a permanent employee who has elected a non-paid leave of absence from State of Maryland employment, who is not eligible for state subsidy of benefits, but is eligible to participate in certain benefits provided by the State of Maryland while on a leave of absence.

AMBE@ means a Minority Business Enterprise that is certified by the Maryland Department of Transportation.

AMember@ means an employee who is eligible to participate in the State of Maryland Benefits Program but does not include the member=s dependents.

AMIS@ means Management Information System.

APart-Time Employee@ means a permanent employee who works less than fifty percent of the standard work week and is not eligible for state subsidy of benefits, but is eligible to enroll in the State of Maryland Benefits Program.

ARFP@ means this Request for Proposals for Point-of-Service (POS).

ASatellite Account Employee@ means an employee of a political subdivision, agency, commission, or organization that is permitted by Maryland law to participate in the State of Maryland Benefits Program.

ASubcontractor@ means an organization or entity that the offeror plans to utilize for the purposes of services covered under this contract.

ATPA@ means Third Party Administrator.

ATTY/TDD@ means a telephone device used by hearing impaired individuals whereby they communicate via telephone connected to a keyboard and screen.

1.3 ISSUING OFFICE AND PROCUREMENT OFFICER

The sole point of contact in the State for purposes of this RFP is the Issuing Office

at the address listed below:

State of Maryland
Department of Budget and Management
Employee Benefits Division
301 West Preston Street, Room 509
Baltimore, Maryland 21201
Attn: Gladys B. Gaskins
Telephone: (410) 767-4710
Fax: (410) 333-7122

The Procurement Officer is Joel Leberknight, 45 Calvert Street, Room 137, Annapolis, Maryland 21401, (410) 260-7116. (Fax: 410-974-3274).

A copy of this RFP also can be obtained from the Department=s Internet Web Site. The address is www.dbm.state.md.us - procurement.

1.4 PRE-PROPOSAL CONFERENCE

A pre-proposal conference will be held on April 19, 1999 beginning at 1:00 p.m. in the auditorium located on the 1st floor, 300 West Preston Street, Baltimore, Maryland 21201. Attendance at the pre-proposal conference is not mandatory, but all interested offerors are encouraged to attend in order to facilitate better preparation of their proposals. The conference will be transcribed. A copy of the transcript of the pre-proposal conference will be made available to potential offerors at a nominal charge directly from the transcription company. In addition, minutes of the conference will be distributed, free of charge, to all vendors who are known to have received the RFP. Both written and verbal questions will be considered at the pre-proposal conference.

All questions, either verbal or written, should be submitted in a timely manner. In

the case of questions not received in a timely manner, the Procurement Officer shall, based on the availability of his time to research and communicate an answer, decide whether he can answer an untimely submitted question before the proposal due date. Answers to all substantive questions which have not previously been answered will be distributed to all vendors who are known to have received the RFP.

1.5 PROPOSAL DUE DATE

Except as provided in COMAR 21.05.02.10, the proposals are to be received by the Issuing Office, no later than May 6, 1999 at 1:00 p.m. Proposals may not be submitted by e-mail or facsimile.

1.6 DURATION OF OFFER

Proposals submitted in response to this RFP are irrevocable for 120 days following the closing date. This period may be extended at the Procurement Officer's request only by an offeror=s written agreement.

1.7 REVISIONS TO THE RFP

If it becomes necessary to revise this RFP, amendments will be provided to all prospective offerors that were sent this RFP or otherwise are known by the Procurement Officer to have obtained this RFP. Acknowledgment of the receipt of all amendments to this RFP must accompany the offeror=s proposal. Failure to acknowledge receipt does not relieve the offeror from complying with all terms of any such amendment.

1.8 CANCELLATION; DISCUSSIONS

The State reserves the right to cancel this RFP, accept or reject any and all proposals, in whole or in part, received in response to this RFP, to waive or permit cure of minor irregularities, and to conduct discussions with all qualified or

potentially qualified offerors in any manner necessary to serve the best interests of the State of Maryland. The State also reserves the right, in its sole discretion, to award a contract based upon the written proposals received without prior discussions or negotiations.

1.9 ORAL PRESENTATION

Offerors may be required to make individual presentations to State representatives in order to clarify their proposals. Representations made during the oral presentation become part of the offeror=s proposal and are binding if the contract is awarded.

1.10 INCURRED EXPENSES

The State will not be responsible for any costs incurred by an offeror in preparing and submitting a proposal, in making an oral presentation, in providing a demonstration, or in performing any other activities relative to this solicitation.

1.11 MULTIPLE AND ALTERNATIVE PROPOSALS

Multiple proposals will not be accepted. An offeror may, however, submit an alternative proposal in addition to a proposal which fully conforms to the requirements of the RFP. Alternative proposals must be clearly labeled as such and follow the same format as the primary proposals but should contain only that information which is different from the primary proposal. Each proposal must be bound separately and prepared in accordance with Section 5 of this RFP.

1.12 ACCESS TO PUBLIC RECORDS ACT NOTICE

An offeror should give specific attention to the clear identification of those portions of its proposal that it considers confidential, proprietary commercial information or trade secrets, and provide justification why such materials, upon request, should not be disclosed by the State under the Access to Public Records Act, Title 10, Subtitle 6, of the State Government Article of the Annotated Code of Maryland. This information is to be placed after the Title Page and before the Table of Contents in both the technical and financial proposals. Respondents are advised that, upon request for this information from a third party, the Department is required to make an independent determination whether the information may be disclosed (see COMAR 21.05.08.01).

1.13 OFFEROR RESPONSIBILITIES

The State will enter into contractual agreement only with the selected offeror. The selected offeror shall be responsible for all products and services required by this RFP. Subcontractors, excluding those used to meet MBE participation goals, must be identified and a complete description of their role relative to the proposal must be included in the offeror=s proposal. Additional information regarding MBE subcontractors is required under paragraph 1.17 below.

1.14 MANDATORY CONTRACTUAL TERMS

By submitting an offer in response to this RFP, an offeror, if selected for award,

shall be deemed to have accepted the terms of this RFP and the Contract, attached as Attachment A. A proposal that takes exception to these terms may be rejected.

1.15 PROPOSAL AFFIDAVIT

All proposals submitted by an offeror must be accompanied by a completed Proposal Affidavit. A copy of this Affidavit is included as Attachment B of this RFP.

1.16 CONTRACT AFFIDAVIT

All offerors are advised that if a contract is awarded as a result of this solicitation, the successful offeror will be required to complete a Contract Affidavit. A copy of this Affidavit is included for informational purposes as Attachment C of this RFP. This Affidavit must be provided at the time of contract award.

1.17 MINORITY BUSINESS ENTERPRISES

A Minority Business Enterprise (MBE) subcontract participation goal of 15 percent of the Total Administrative Fees found in A.1 of Exhibit 1, page 2 of Attachment H, has been established for this procurement. The contractor shall structure its awards of subcontracts under the contract in a good faith effort to achieve the goal in such subcontract awards by businesses certified by the State of Maryland as minority owned and controlled. MBE requirements are specified in Attachment D of this RFP.

A current directory of MBEs is available through the Maryland State Department of Transportation, Office of Minority Business Enterprise, P.O. Box 8755, B.W.

I. Airport, Maryland 21240-0755. The phone number is (410) 865-1244.

1.18 ARREARAGES

By submitting a response to this solicitation, each offeror represents that it is not in arrears in the payment of any obligations due and owing the State of Maryland, including the payment of taxes and employee benefits, and that it shall not become so in arrears during the term of the contract if selected for contract award.

1.19 PROCUREMENT METHOD

This contract will be awarded in accordance with the competitive sealed proposals process under COMAR 21.05.03.

1.20 CONTRACT DURATION

The contract resulting from this RFP shall be for the period beginning on or about August 1, 1999 and ending on or about May 30, 2003. The offeror shall be responsible for providing POS plan services to employees, retirees and their dependents for calendar years 2000, 2001 and 2002. The State, at its sole option, shall have the right to extend the contract term for two additional, successive one year terms. Following termination of this contract (and any one-year extension exercised by the State), the contractor shall be responsible for handling claims runout payments from the last calendar year period covered, while the new vendor would be responsible for all new enrollees.

1.21 CONTRACT TYPE

The contract to be awarded shall be a fixed price contract.

SECTION 2. OFFEROR QUALIFICATIONS

Offerors must demonstrate the following qualifications. Offerors must clearly state and demonstrate as indicated in Section 5.2.1 that they meet each qualification and provide reference to the page number in their proposal where such evidence can be found. Offerors should also state within the Executive Summary of their proposals that they satisfy each qualification. These qualifications are applicable to the primary offeror and any sub-contractors used by the offeror for primary functions under the Scope of Work. The offeror=s proposal must demonstrate:

A. Three years experience in providing a managed care network in Maryland for at least 15,000 enrolled employees (to include HMO and POS covered lives, but not any other types of plans).

B. Compliance with the Maryland Insurance Administration=s licensing and registration requirements for POS plans, including certification of liability insurance.

C. Commitment to meeting CHAMP data reporting requirements within ninety days of contract award using unscrambled data. (See Attachment F for details on the CHAMP data reporting format.)

D. Be accredited by (NCQA) or (JCAHO) or some similar national

accreditation body and meet (HEDIS) or (CAHPS) data reporting guidelines.

E. Commitment to meet all State mandated benefit levels.

SECTION 3. SPECIFICATIONS

3.1 DESCRIPTION OF CURRENT PROGRAM

The State of Maryland currently offers its members one preferred provider organization (PPO) plan which is geographically aligned, three point of service (POS) plans, and seven health maintenance organization (HMO) plans as follows:

Vendor	Plan Type
Blue Cross Blue Shield - Central Maryland	PPO
MLH Eagle - Wash. Metro Area/ Southern MD/ Eastern Shore/ Western MD	PPO
Blue Cross Blue Shield - Blue Plus	POS
M.D.I.P.A. Preferred	POS
NYL Care	POS
Free State	HMO
George Washington University	HMO

Kaiser Permanente	HMO
NYL Care	HMO
Optimum Choice	HMO
Prudential	HMO
United Healthcare	HMO

There are approximately 100,000 state employees, retirees, satellite organization employees, and direct pay employees enrolled in the State=s medical plans. Percentages enrolled are:

PPO plans - 43 %

POS plans - 32 %

HMO plans - 25%

Active employees, retirees, satellite organization employees and their eligible dependents receive state subsidized health benefit coverage. Eligible dependents include children through the end of the calendar year in which they attain age 19, or age 25 if enrolled as a full-time student.

Summaries of current plan coverage are provided in Attachment J. A diskette with employee demographic and plan participation information is available to all vendors that request the information. Information on the diskette may only be used in response to this RFP. A confidentiality agreement (Attachment E) will need to be provided to the State to ensure that the information will only be used as set forth in this RFP.

3.2 BACKGROUND

The State provides an expansive range of employee benefit plans to approximately 70,000 active employees, 27,000 retirees, 2,000 Satellite account employees, 1,500 Direct Pay enrollees, and their covered dependents. Benefit plans include health, dental, group term life, accidental death and dismemberment, flexible spending accounts, prescription, mental health, and

vision.

These benefits are offered to a diverse workforce that includes clerical, administrative, technical, professional, maintenance, educational (State colleges and universities), public safety, appointed and elected officials at more than 250 different worksites.

Due to the large number of State employees, diverse population and numerous employee work locations, the State sponsors annual Benefit Fairs during each annual open enrollment period. During the Fall 1999 Open Enrollment, the State conducted 100 Benefit Fairs throughout the State.

The University of Maryland at Baltimore (UMAB) is currently conducting a study of the feasibility of implementing an additional medical plan option. If this plan option is implemented, it would be available as an additional option to the State=s normal range of medical benefit plans. The plan option would be available only to UMAB employees and their dependents (total potential enrollment of 3,100 employees). The pilot program would be effective January 1, 2000 and would run for three to four years.

3.3 SCOPE OF WORK

The State is soliciting proposals for no more than three (3) vendors to provide POS health insurance benefits to state members and is seeking qualified vendors who meet the requirements under Section 2 and who will provide a responsive, efficient, auditable, service-oriented system that will:

A. Permit all eligible members to obtain health insurance benefits for themselves and their dependents.

B. Ensure timely, accurate and prompt processing of claims either by a paper process or electronic process.

C. Administer the plan to provide Coordination of Benefits (COB) with other employee, retiree and dependent medical coverage.

D. Deliver a management information reporting system that provides utilization, claims reporting, and administrative services data by employee group to the State of Maryland.

E. Establish and provide a dedicated, state-of-the-art customer service operation that is available to plan members (both in-state and out-of state) from at least 8:00 a.m. to 5:00 p.m. Monday through Friday, except on State observed holidays, local time in Maryland. The customer service operation should also include a toll-free customer service line equipped with an automated voice response system that members (both in-state and out-of state) can access directly 24 hours a day, 7 days a week, to request and receive service authorizations or other pertinent data. Claim forms (if used) must be mailed to members within two business days from the date of request. The customer service operation must include:

a. Qualified staff available to answer questions on plan eligibility, plan guidelines, benefit levels, and claims procedures. Disabled individuals must be provided adequate access to the customer service system.

b. An information system capable of electronically transmitting, receiving, and updating member profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.).

c. The ability to maintain an eligibility file that identifies eligible members as well as certain other pertinent information regarding members.

d. A system for providing Explanations Of Benefits to eligible members detailing payments to facilities and providers for services rendered and the amounts applicable to each service.

F. Convert State data files, including the State master enrollment file and any other relevant files to the vendor=s data system.

G. Offer support services for the 1999 Open Enrollment period (for the plan year beginning January 1, 2000) and subsequent open enrollments.

H. Guarantee that in the event a health care provider is not paid accurately for services rendered, that the member shall not be liable to the provider for any sum owed by the health plan other than those not covered by the plan.

I. Have a procedure for resolving complaints in place and operable on the date of contract award. The State expects that an expeditious, written resolution will normally be mailed within 10 workdays of receipt of the complaint.

J. Maintain and verify documentation of student status and disabled status for dependents of eligible state members.

K. Share the expenses for printing the State of Maryland Open Enrollment booklet and universal enrollment forms, costs for which will be shared equally among all benefit plans, including medical, dental, prescription drug, mental health and substance abuse, life insurance, personal accident and dismemberment and long-term care insurance vendors.

L. Put at least 10% of your total administrative and capitation fees at risk for failure to provide satisfactory administrative services, subject to an external audit.

M. Provide guaranteed administration fees and guaranteed capitation rates.

N. All vendors will be held accountable for meeting or exceeding established performance standards as described in Attachment I and as subsequently agreed to by the contractor and the State.

O. Participate in period managed care quality evaluations sponsored by the State and share in the expenses for conducting and communicating the results of such evaluations to State employees, retirees and dependents.

P. The State intends to continue its current payment procedures outlined below.

Claims:

< State maintains a Working Fund Account for each plan at the State=s bank (Signet).

< Plan submits weekly invoice to the State for claims processed.

< The State will transfer money from the State account to the Vendor=s Bank Account the day after receipt of the invoice (if the invoice is received in the morning). If the day after receipt is a week-end day or holiday the transfer will be made on the next business day.

Non-claims (Administrative and Capitation Fees)

< Invoice submitted to the State on a monthly basis.

< Invoice processed through normal State transmittal process (i.e., transmittal sent to Annapolis, 7 to 10 days turnaround time, ACII transfer or check to vendor).

Q. SPECIAL PROVISIONS: Vendors must agree to:

A. Meet on a quarterly basis with the State.

B. Provide reports as specified by the State.

C. Provide adequate staff for approximately 100 Open Enrollment meetings. Requests for changes in staffing would need to be submitted to the State in writing for approval.

D. Send evidence of coverage or summary plan descriptions to each enrollee.

E. Send provider directories to all POS enrollees.

F. Provide Geo-Access data to the State of Maryland as needed for this RFP.

G. Provide for records retention according to state regulations.

3.4 DESIRED PLAN DESIGN

The State intends to offer health insurance programs that provide a reasonable array of health benefits at an affordable cost to members. The new contract(s) resulting from this procurement will include a no-loss, no gain provision under which no person will lose coverage because of a plan administrator or contractor change. Also, the actively-at-work requirement will be waived for employees and dependents not performing normal work activities on the effective date.

Offerors are requested to submit a proposed health insurance design that will meet these criteria. If the offeror is unable to provide a requested provision, the offeror should explain that inability and any resultant differences in the plan being proposed in the Executive Summary section of their proposal. Substantial

differences will be a factor in the final determination. The State reserves the right to reject any plan with susbstantial differences. The offeror=s proposed design should incorporate the following plan options:

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
Deductibles Individual Family	None None	$250 $500	None None	$250 $500	None None
Out of Pocket Maximums* Individual Family *Any fees above the plans allowed amount are not counted toward the Out of Pocket Maximum.	None	$3,000 Individual $6,000 Family	None	$3,000 $6,000	None
Lifetime Maximums	The Lifetime Maximum per each covered individual [i.e. employee or retiree, spouse, child(ren)] is $2 million per lifetime.				
Physicians Primary Care Office Visit	100% after $15 copay	80% after deductible	100% after $5 copay	80% after deductible	100% after $5 copay
Specialist Office Visit	100% after $20 copay	80% after deductible	100% after $10 copay	80% after deductible	100% after $10 copay
Annual GYN Exam	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Outpatient Surgery	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Benefit	PPO In-Network Coverage	PPO Out-of-Network Coverage	POS In-Network Coverage	POS Out-of-Network Coverage	HMO Coverage (All care must be preauthorized)
Hospitalization	100% for 365 days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Surgery	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Anesthesia Services	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Maternity Benefits (Includes: pre/post natal care and delivery. 2nd opinion required for non-emergency C-section)	100%	80% after deductible	100% when preauthorized by Plan	80%after deductible	100% when preauthorized by Plan
Newborn Care (must be enrolled within 60 days of birth)	100%	80% after deductible	100% for enrolled newborn when preauthorized by Plan	80% after deductible	100% for enrolled newborn when preauthorized by Plan
Diagnostic Lab & X-ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chiropractic Services	100% after $20 copay	80% after deductible	100 % when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

Acupuncture Services for Chronic Pain Management	100% after $20 copay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
Whole Blood Charges	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100$ when preauthorized by Plan
Medical Supplies (Includes but not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment & machines; and all diabetic supplies as mandated by Maryland law) Contact Plan for details on covered items.	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Organ Transplants X Per calendar year for cornea, kidney, and bone marrow	100% 100%	80% after deductible 80% after	100% when preauthorized by Plan 100% when	80% after deductible 80% after	100% when preauthorized by Plan

X	Per 365 days up to $1 million per heart, heart-lung, single or double lung, liver, and pancreas		deductible	preauthorized by Plan	deductible	
Benefit		**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
Durable Medical Equipment NOTE: Contact Plan for further details on covered items.		100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chemo-therapy/ Radiation		100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan Benefit
Therapies* - Occupational Therapy (up to100 visits per year when combined with Physical Therapy - Physical Therapy (up to 100 visits per year when combined with Occupational Therapy - Speech Therapy (up to 50 visits per year)		100%	80% after deductible	100% after $10 copay	80% after deductible	100% after $10 copay

***For children ages 0-19, conditions related to congenital or genetic birth defects or diseases, these services may be covered under the plan=s Case Management services. Call the plan for further information.**					
Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
Orthopedic/ Prosthetic Devices (Replacements covered when preauthorized by plan)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Private Duty Nursing (Must be preauthorized for all plans)	100%	80%after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Second Opinion (Surgical)	100%	100%	100%	100%	100% when preauthorized by Plan, or when required by Plan
Ambulance Services	100% for medical emergencies	100% for medical emergencie	100% for medical emergencies	100% for medical emergencie	100% for medical emergencies

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Urgent Care Centers	$10 copay	$10 copay 80% after deductible	$10 copay	$10 copay 80% after deductible	$10 copay
Emergency Room Services - Inside and Outside of Service Area	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment	100% after $25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan coverage is 50% of allowable amount, plus $25 copayment
NOTE: Emergency Services or Medical Emergency: Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: 1. Placing the patient's health in jeopardy; 2. Serious impairment of bodily functions; or 3. Serious dysfunction of any bodily organ or part.					
Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**

Mental Health/ Substance Abuse	NOT COVERED BY PLAN Covered by State Mental Health Plan	NOT COVERED BY PLAN Covered by State Mental Health Plan	NOT COVERED BY PLAN Covered by State Mental Health Plan	NOT COVERED BY PLAN Covered by State Mental Health Plan	100% for in-patient care up to 365 days when preauthorized by Plan. 80% for outpatient care, visits 1-5; 65% for outpatient care, visits 6-30; 50% for outpatient care, visits 30+ per calendar year
Extended Care Facility (for up to180 days per calendar year of skilled nursing care when medically necessary)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Hospice	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Home Health Care (for up to 120 days per calendar year)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Mammography/ Pap Test	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Family Planning & Fertility Testing (Including: sperm count	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

hysterosalpingography, endometrial biopsy, IUD insertion, vasectomy, tubal ligation. Only 1 reversal covered per lifetime)					
Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
In Vitro Fertilization (IVF) and Artificial Insemination Note: Contact your plan for further details on Preauthorization Requirements. Member must be covered under any State benefit plan for 1 year to be eligible for this benefit and must be married.	100% for up to 3 attempts per lifetime - either IVF or Artificial Insemination	80% after deductible for up to 3 attempts per lifetime - either IVF or Artificial Insemination	100% when preauthorized by Plan for up to 3 attempts per lifetime - either IVF or Artificial Insemination	80% after deductible for up to 3 attempts per lifetime - either IVF or Artificial Insemination	100% when preauthorized by Plan for up to 3 attempts per lifetime - either IVF or Artificial Insemination
Norplant Surgery Only	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Well-Baby Care Under 1 year: 6 visits; 1-2 years: 2 visits; 2 years +: 1 visit per yr	100% after $15 copay per visit, to age 12	80% after deductible per visit, to age 12	100% after $5 copay per visit, to age 12, when preauthorized by Plan	NOT COVERED	100% after $5 copay per visit, to age 12, when preauthorized by Plan

Immunizations as recommended by the American Medical Association and the American Academy of Pediatrics, including immunizations required for participation in school athletics, and including Lyme Disease Vaccine. (Contact your plan for further details)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Physical Exams - 1 every 3 years for all members and their dependents	100% after $15 copay	80% after deductible	100% after $5 copay if preauthorized by Plan	NOT COVERED	100% after $5 copay for exam when preauthorized by Plan
Benefit	**PPO In-Network Coverage**	**PPO Out-of-Network Coverage**	**POS In-Network Coverage**	**POS Out-of-Network Coverage**	**HMO Coverage (All care must be preauthorized)**
Hearing Examinations and Hearing Aids	100% after $15 copay for exam. 100% for Std. Model hearing aid. 1 exam and hearing aid every 3 years for each employee	80% after deductible	100% after $5 copay for exam when preauthorized by Plan. 100% for Std. Model hearing aid. 1 exam and hearing aid every 3 years for each employee and	NOT COVERED	100% after $5 copay for exam when preauthorized by Plan. 100% for Std. Model hearing aid. 1 exam and hearing aid every 3 years for each employee and dependent.

	and dependent.		dependent.		
Allergy Testing	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Diabetic Nutritional Counseling as mandated by Maryland law	100% after $15 copay	80% after deductible	100% after $5 copay when preauthorized by Plan	80% after deductible	100% after $5 copay when preauthorized by Plan
Prescription Drugs	NOT COVERED UNDER MEDICAL PLAN				
Dental Services	NOT COVERED UNDER MEDICAL PLAN				
Vision -- Any services that deal with the medical health of the eye	100% after $15 copay (primary care physician) or $20 copay (specialist)	80% after deductible	100% after $5 copay or $10 copay (specialist) when preauthorized by Plan	80% after deductible	100% after $5 copay or $10 copay (specialist) when preauthorized by Plan

Vision - Any services that deal with correction vision.	**Plan Pays Up To: Exam** - $45 (Available once every year) **Prescription Lenses** (per pair) - (Available once every year) X Single Vision - $28.80 X Bifocal, single - $48.60 X Bifocal, Double - $88.20 X Trifocal - $70.20 Aphakic: Glass - $54.00 Plastic - $126.00 Aspheric - $162.00 **Frames** - $45 (Available once every year) **Contacts** (per pair, in lieu of frames and lenses) (Available once every

year)

X Medically Necessary - $201.60

X Cosmetic - $50.40

General Limitations and Exclusions

This is a general summary of limitations and exclusions. This list is subject to change at any time. Please call the plan for further information.

The State does not cover services and supplies:

- for services not deemed medically necessary by the Plan,
- not prescribed, done, or guided by eligible practitioners,
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons,
- provided through a dental or medical department of an employer, a mutual benefit association, a labor union, a trust, or a similar entity,
- for personal hygiene, cosmetic and convenience items, air conditioners, humidifiers, exercise equipment, elevators or ramps, even if recommended or prescribed by a physician,
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services,
- for separate billings for services or supplies furnished by an employee or a hospital or practitioner which are normally included in such hospital=s or practitioner=s charges and billed for by them,
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner,
- for treatment of a patient who is discharged from a hospital, facility, or institution and readmitted within 14 days after their effective date when such discharge and readmission was for the purpose of qualifying for coverage under this benefit plan,

- for court-ordered examinations, care, or confinement, unless otherwise medically necessary,

- rendered or available under any Workers= Compensation or occupational disease, or employer=s liability law, or any other similar law, even if the member fails to claim benefits,
- that are excluded from coverage under Medicare,
- to the extent the services and supplies are provided under Medicare,
- for the treatment of any injury, illness, or medical condition that is not medically necessary,
- for illnesses resulting from an act of war,
- for any illness due to a criminal act if the member is the principal or aids in its commission,
- for cosmetic surgery, or cosmetic surgery performed to treat a psychiatric or emotional condition except as may otherwise be specifically provided in this benefit plan,
- for sex changes,
- primarily for custodial care or rest cures,
- that are provided for care of any kind in connection with habilitation,
- cardiac rehabilitation when not done because of single-lung, double-lung, heart, or
  heart-lung transplant,
- for conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for hospital stays for environmental change,
- for milieu care or In-Vivo therapy,
- for non-medical or non-surgical self-care or self-help training,
- for treatment of obesity (except morbid obesity), weight reduction, or dietary control,

- for routine podiatry care unrelated to diabetes mellitus and peripheral vascular disease and diabetic neuropathy,
- for inpatient private duty nursing services,
- diagnostic services for:
  - the interpretation of clinical lab tests, such as blood counts, when practitioner=s service is only administrative
  - fluoroscopy without films
  - care of teeth
  - tests not ordered by a practitioner
  - research tests
  - screening tests when there are no symptoms or patient complaint except for routine examinations except as mandated by law
  - pre-marital exams
- a transplant or procurement done outside the continental U.S.
- covered services if there are research funds to pay for the covered services,
- services or supplies to the recipient or companion(s) if no payment is required,
- expenses incurred for the location of a suitable donor, e.g. the National Bone Registry.

3.5 DELIVERABLES/DELIVERY SCHEDULE

The State desires that the offeror meet the following implementation schedule:

DATE	ACTIVITY
Upon contract commencement	Begin implementation meetings with the State of Maryland

Within 7 calendar days of contract commencement	Start information transfer and vendor activities/transition protocols
21 calendar days after contract commencement	Completion of information transfer activities
30 calendar days after commencement award	Completion of vendor implementation plan/transition protocols
Last week of September, 1999	Benefit Coordinators Training Sessions
October, 1999	Open Enrollment and Benefit Fairs
January 1, 2000	Commence Benefit Coverage

3.6 QUESTIONNAIRE

The purpose of these questions is to obtain information to assist the State in its evaluation of offeror capabilities in terms of the evaluation criteria identified in Section 4 of this RFP. The responses in this section will be an important component in the evaluation. In responding, offerors should repeat each question, followed by the answer. Answers should be concise, but complete. Offerors must respond specifically to each question in this section, regardless of whether the information appears or may be gleaned from other sections of the offeror=s proposal. Failure to respond in this section to all questions may result in rejection of the offeror=s proposal. To assist offerors in the preparation of their responses, a disk copy of this questionnaire in WordPerfect 6.1 format is available.

Organization Name: _____

_____

Primary Contact: _____

Title: _____

Headquarters Address: _____

_____

Telephone Number: ( ) _____

Fax Number: ( ) _____

E-Mail Address: _____

1. Provide a brief summary of the history of your company and information about the growth of your organization on a national level and within the State of Maryland.

   Provide the following information about your company:

   a. Organization's legal name
   b. State of incorporation
   c. Date of incorporation

d. Insurance certification from the Maryland Insurance Administration

2. Describe any significant government action or litigation taken or pending against your company or any entities of your company during the most recent five (5) years.

3. Provide the addresses, including city and state, for the following activities:

a. Corporate/Firm Management Office
b. Customer Service Office
c. Provider Service Office
d. Account Management/Client Services Office
e. Technical Support Office

4. Provide the names, location, telephone numbers and brief resumes for each of the following proposed contacts for the State of Maryland:

a. The person representing your company during the proposal process.
b. Primary account service representative.
c. Account manager.
d. Medical director, including specialty, percentage of time spent as medical director versus private practice, and if not currently practicing medicine, identify the last year in private practice.

5. Explain your organization's ownership structure, listing all separate legal entities. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.

6. Describe how long the current ownership structure has been in place.

a. Note any changes in ownership structure that have occurred within the last two years.
b. Note any changes in ownership structure anticipated to occur within the next two years.
c. List any ownership interest your company has in any business that provides a service or product related to medical care. Describe the relationship.

7. Do you have contractual relationships with third party administrators/organizations in which you pay service fees or other fees that your client directly or indirectly is charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.

8. Are your networks solely owned and operated by your organization? If not, explain the contractual relationship you have with outside parties. Describe and include copies of any leasing arrangements currently in effect.

9. Provide a profile of your group medical plan business for each of the latest three calendar years (1998, 1997 and 1996). Include: total premium volume, total number of clients, total number of participants covered, number and average size of public sector clients, number of public sector participants, number of claims handled, and number and average size of plans terminated during each year.

10. Provide copies of the most recent reports on your company's claims paying ability from the rating services of Standard & Poor, Moody's, Duff and Phelps and Best's. (If you are not rated by one or more of these organizations, please state so). Has there been any change in your ratings in the last two (2) years? If yes, explain the nature and reason(s)

for the change.

11. Provide the following:

    a. copies of your company's Annual Reports for your most recent three fiscal years.
    b. a copy of your most recent quarterly financial statement filed with the Maryland Insurance Administration.

12. What fidelity and surety insurance, general liability and errors and omissions or bond coverage do you carry to protect your clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.

13. Describe your company's experience in providing Point of Service group medical benefits. How long have you offered plans to Maryland based clients?

14. List three (3) of your largest current POS group clients. For each client provide:

    a. Client name and address.
    b. Name, title and telephone number of a person we may contact.
    c. Number of employees/retirees covered and total employees/retirees of the client.

15. List your three (3) largest current POS group medical plan clients located in Maryland. For each Maryland client provide:

    a. Client name and address.
    b. Name, title and telephone number of a person we may contact.
    c. Number of employees/retirees covered and total

employees/retirees of the client.

16. List three (3) former POS group medical clients that have terminated their contracts with your organization within the last 24 months. For each terminated client provide:

a. Former client name and address.
b. Name, title and telephone number of a person we may contact.
c. Number of employees/retirees covered and total employees/retirees of the client.
d. The reason(s) for terminating the contract.

17. If your company is presently providing POS services to the State, provide a self-assessment of your performance under the current contract (Limit response to 2 page).

18. What key features distinguish your POS product from your competitors and what do you perceive as your competitive advantages? Who do you view as your primary competitors for POS group medical benefit plans? (Limit response to 1/2 page).

Subcontractor Information - NOTE: Although the following three questions are preferred to be submitted with your proposal, the offeror is not required to identify MBE subcontractors until 10 working days after the contract is awarded.

19. Do you now subcontract with any other organization(s) for professional services? If so, provide a description of your subcontracting arrangements.

20. Does your company currently have or plan to have offices or use subcontractors that have offices located in the State of Maryland?

21. Provide the same information requested in Questions 1 through 7, 12, and 14 through 16 for each subcontractor that the offeror proposes to have perform any of the required functions under this contract. Clearly identify if a proposed subcontractor is a minority business enterprise certified by the State.

22. What office would handle the general servicing of this account?

23. Describe how member services and claim processing systems are integrated.

24. a. Provide a percentage breakdown of the administration fees you are quoting in the financial proposal. Note: DO NOT INCLUDE ACTUAL DOLLAR AMOUNTS, ONLY PERCENTAGES.

Claims Administration/Payment	_____	%
Risk Charges	_____	%
Contingency Charges	_____	%
Taxes	_____	%
Profit	_____	%
Other (specify) _____	_____	%
TOTAL		100%

b. How will administrative service fees be billed and collected?

25. The State requires fully dedicated customer service representatives and supervisors to be assigned to this account. Would this dedicated unit provide service for any other clients? Furnish a staffing plan with the number and title of employees to be assigned to this unit.

26. Are customer service representatives separate from the claim processing unit, or do claim processors have customer service responsibilities? Do customer service representatives have on-line access to up to date claim processing information? Do customer service representatives have authority to approve claims? What access is provided to the medical director?

27. Confirm that a toll free number will be available to the plan sponsor and participants to handle claims or other service issues. Identify how many toll free telephone lines will be established for this group? What hours will the telephone lines be staffed?

28. For the State's designated service office, how are emergencies, or non-office hour admission requests handled?

29. Identify your goals and actual telephone response statistics for the prior calendar year based on the following categories:

(a) 100% of all calls answered within ___ seconds, during normal business hours
(b) Telephone call abandonment rate
(c) Call on hold (in-queue time)

30. Describe the grievance protocols in place for plan participants. What is your response time goal for which to respond to claim and other questions and complaints? Provide actual response time statistics for the most recent year.

31. Provide a sample of a new member communications package, including information on:

(a) Location of providers
(b) How to use network services
(c) How to access member services
(d) How to file non-network claims

32. Provide a draft plan description to be included in the Open Enrollment

booklet. The plan description must describe in detail the procedures to be used by eligible members to obtain health services. To assist offerors in the preparation of this draft, a copy of the plan description included in the Summary of Health Benefits booklet for the plan year beginning January 1, 1999 is included as Attachment G.

33. Do you provide member support services for selecting and/or locating network physicians and for answering provider credential questions that members may have? Do you have on-line access to network provider listings and locations to assist members with provider selection? What other member services are provided with regard to provider selection assistance (i.e., arrangements for changing PCPs).

34. How often are provider directories updated and dispersed to plan members? What other directory formats are available (e.g. Internet)?

35. What assistance do you provide plan members if a network physician terminates his or her contract during the plan year? How and when are members notified? What happens to patients that are receiving on-going treatment from that network physician?

36. Can the plan sponsor or plan participant nominate providers to be considered for inclusion in the network panel? If so, what steps would be required to be taken by the plan sponsor and/or participant?

37. Do you monitor waiting times for patients seeking appointments? If so, what is the average number of working days between the date an appointment is made and the actual visit, for non-emergency care? for Urgent Care?

38. Will you agree to notify the contract holder immediately if the network loses any accreditation, licenses or liability insurance coverage, security

or bonding?

39. For each claim office that will be employed, provide the following:

Location(s) _____

Years in operation _____

Hours of operation _____

Current Staffing	# of	Avg. Yrs Experience	Annual Turnover Rate (%)
Processors	_____	_____	_____
Supervisor	_____	_____	_____
Managers	_____	_____	_____
RNs	_____	_____	_____
MDs	_____	_____	_____

Annual Claim Volume _____

# of Claims/Processor _____

# of Plans Presently Administering _____

40. The State requires fully dedicated claims adjustors and supervisors to be assigned to this account. Would this dedicated unit provide service for any other clients? Furnish a staffing plan with the number and title of employees to be assigned to this unit.

41. Provide a brief biography of the claim management/supervisory staff members that will be assigned/responsible for this account.

42. Describe the training received by claim processors, supervisors and other

management staff.

43. Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. Will all claims be paid in accordance with the benefit program described in the specification letter? If the process is different for network and non-network claims please discuss separately.

44. For the claim office proposed, what is the number of working days for a claim to be processed (check issued) from the date of receipt, without coordination of benefits? On what basis do you make that representation (e.g., average turnaround time over the past 12 months)? Describe separately for network and non-network claims, if results vary by type of provider.

What percent of claims are processed within 10 working days:

_____

What percent of claims are processed within 30 working days:

_____

How do the above results compare to internal goals?

45. For the claim office proposed, provide the following for the last two calendar years:

- Financial accuracy as a percent of total claims dollars paid (include over/underpayments)
- Coding accuracy as a percent of total claims submitted

46. When and under what circumstances are claims Apended@? Does a pending

notice go into the system? Is there an automatic follow-up? What is the frequency of the follow-up? How many follow-ups are performed?

47. How do you avoid duplicate payments of the same claim? If duplicate payments or overpayments are made, what are your procedures for recovery of the overpayments or duplicate payments?

48. Describe the methods used to track claims? If on-line, can claim tracking be made available to clients?

49. Describe how eligibility is verified.

50. Describe your administrative requirements with respect to direct pay claims.

51. How do you handle claims backlogs (e.g., overtime, switch to another office)?

52. Submit samples of all forms that would be used in the administration of this plan including at least a claim form, completed EOB and ID cards. Are any forms required for plan administration, the cost of which are not included in your retention?

53. Explain your COB procedures and the average savings that you obtain and how COB savings are calculated. Do you pursue COB prospectively or retrospectively to payments? Provide savings with and without Medicare COB? How do you know if there is other coverage? How often are records updated for new information on other coverage?

54. Can you administer COB on a basis other than the birthday rule? If you are the secondary payor, is your COB based on a 100% benefit, the coinsurance in effect on the primary carrier's plan, or the coinsurance level in effect on your (secondary) plan?

55. Explain your standard subrogation policy provisions and procedures and any options that are available, along with their advantages and disadvantages.

56. Can you coordinate your claim administration with a UR firm other than your own? How is that accomplished and what is your past experience with this kind of arrangement?

57. How do you determine whether physician and/or hospital charges submitted were for services actually rendered?

58. Explain how unusual claims and/or charges are handled. Do you retain medical consultants for the review of any unusual claims or charges? If yes, explain the method in which such consultants are used and describe their qualifications. Also, indicate the savings in claim costs that are attributable to the use of these consultants and how that amount of savings is calculated. Does this outside organization or person have any other business or personal relationship with your organization or any member of your organization? If so, what is the relationship?

59. Explain any other special claim administration procedures that you employ to achieve savings on claim payments, such as special investigations of claims, unbundling of claims, etc. Include a description of each procedure, indicating

whether these procedures are optional or automatic and the savings you typically achieve by using them. Explain how savings are calculated.

60. Describe your utilization review procedures. Include the role of primary care physicians and specialists in the utilization review process.

Your answer should address:

Preservice / Pre-certification
Concurrent and Retroactive Review of on-going treatment
Second Surgical Opinions
Large Case Management
Ability to provide utilization statistics and savings report
UR staff credentials and qualifications
UR staff training programs and monitoring
Appeals process
Systems edits and on-line access to supporting information
Psychiatric and substance abuse precertification
DRG validation

High risk maternity screening management
Coordination with PBM regarding medical necessity

For each component noted above be sure to provide:

The qualifications of personnel performing the stated task
The timing requirements of each task
How standards where developed
How information is captured and results are monitored

61. What is the process for assigning pre-certification, Second Surgical Opinion, large case management cases, and appeals to physicians for review? What percent of cases typically require physician involvement? At what point is physician involvement initiated?

62. Provide the percentage of in-take telephone calls handled directly by RNs, LPNs, other clinically trained personnel, non-clinically trained personnel?

63. In what form and how quickly is notification of utilization review provided to the attending physician, hospital, patient, claim administrator, client?

64. What is your typical turnaround time for your pre-certification service (from the time a call is initiated by the plan participant or provider to the time a phone determination is given and written confirmation is released)?

65. What criteria are used to identify cases for medical case management? If a list is used, please provide a copy of the list. When and how is case management

initiated?

66. How and when are medical specialists involved in the case management process?

67. How does your organization prevent over and undertreatment? Give examples.

68. Describe the patient appeals policy and process.

69. Do you have a pre-authorization procedure for referrals to non-network providers? If so, explain.

70. What criteria are used to determine what procedures require a second opinion? Is a standard second surgical opinion list used? Can second opinions be obtained from physicians outside the network? If so, is the cost covered by the plan?

71. What utilization/encounter information do you require your network providers to report? Describe the process of how this information is provided.

72. Explain any contractual relationships with outpatient facilities such as imaging centers, surgical centers, and laboratories. Are referrals restricted to contractual facilities only? What utilization controls are in place with these facilities to reduce the number of unnecessary services being performed?

73. Complete the following utilization tables based on actual network results for

your in-network members for the latest two calendar year periods available.

Table 73a - Inpatient ALOS and Discharges Per 1,000 Members by ICD-9 code

Table 73b - Hospitalization Pre-certification and Continued Stay Review

Table 73c - Inpatient Utilization by Age and Sex

Table 73d - Outpatient Utilization by Age and Sex

Results should be based on only those eligible members and groups that were covered for the full calendar year periods.

Table 73a - Inpatient ALOS and Discharges Per 1,000 Members by ICD-9 code Time Period:

ICD-9 Code	Description	# of Discharges	Days Per 1,000 Members	Average Length of Stay	# of Readmits Within 30 Days
29620	Depressive Psychosis				
41400	Coronary Atherosclerosis				
30390	Alcohol Dependency				
48600	Pneumonia				
42800	Congestive Heart Failure				
41110	Intermed. Coronary				
65000	Normal Delivery				
78650	Chest Pain				
78900	Abdominal Pain				
49600	Chronic Airway Obstruction				
72210	Lumbar Disc Displacement				
18500	Malig. Neoplasm- Prostate				
49390	Asthma				
16290	Malig. Neoplasm -Lung				
55890	Non-Infect Gastroenteritis				
57200	Acute Pancreatis				
65421	C-Section Delivery				

59880	Urine Tract Infection				
56211	Diverticulitis of Colon				
21890	Uterine Leiomyoma				

Table 73b - Hospitalization Pre-certification and Continued Stay Review Time Period:

Category	Med/Surg		All	
	Network	Non Network	Network	Non Network
Admissions Requested				
Admissions Certified				
Actual Admissions				
Admissions Averted				
Avg. Cost / Active Admission				
Savings				
Days Requested				
Days Certified				
Actual Days				
Days Reduced				
Avg. Cost/Day				
Days Savings				

For purposes of this table:

Admissions Averted = Admissions requested *less* actual admissions.

Admission Savings = Admissions averted *times* average cost/admission.

Days Reduced = Days requested *less* actual days.

Days Savings = Days reduced *times* cost/day.

Table 73c -Inpatient Utilization by Age and Sex Time Period:

Age/Sex	Discharges	Discharges per 1,000 members	Days per 1,000 members	Average Length of Stay
Male 0-19				
20-29				
30-39				
40-49				
50-59				
60-64				
65+				
Total Male				
Female 0-19				
20-29				
30-39				
40-49				
50-59				
60-64				
65+				
Total Female				

Table 73d - Outpatient Utilization by Age and Sex Time Period:

	PCP Office Visit		Emergency Rm Visit		Specialist Referrals	
Age/Sex	# of	Per 1,000 Members	# of	Per 1,000 Members	# of	Per 1,000 Members
Male 0-19						
20-29						
30-39						
40-49						
50-59						
60-64						
65+						
Total Male						
Female 0-19						
20-29						
30-39						
40-49						
50-59						
60-64						
65+						

Total Female						

Table 73d - Outpatient Utilization by Age and Sex (continued) Time Period:

	Surgical Procedures		Radiological Procedures		Pathological Procedures	
Age/Sex	# of	Per 1,000 Members	# of	Per 1,000 Members	# of	Per 1,000 Members
Male 0-19						
20-29						
30-39						
40-49						
50-59						
60-64						
65+						
Total Male						
Female 0-19						
20-29						
30-39						
40-49						
50-59						
60-64						
65+						

Total Female						

74. The State contracts with HCIA for their CHAMP data system. The data elements shown on Attachment F must be reported to HCIA on a calendar quarter basis. Data must be provided to HCIA with actual Social Security numbers pursuant to a confidentiality agreement the offeror will enter into with HCIA. Reports are due to HCIA no later than the 10th business day of the month following the end of each calendar quarter. Confirm your ability to comply with these requirements.

75. The State requires a number of regular monthly, quarterly and annual claim reports. Indicate for each of the following reports: whether or not you can provide such a report, and the frequency and timing of each report. Provide an example of each type of report.

(a) A monthly paid claims summary for all benefit payments made during the month. The summary should show separately for employees and dependents, the eligible charges submitted, amount paid during the month, and the number of claims paid. (i.e., the number of checks or drafts issued).

(b) Monthly in and out-of-network utilization showing information noted above in (a) by in and out-of-network.

(c) UCR cost savings by individual claim, listing the CPT code, submitted charge, allowable charge, zip code of the provider, ID# of the provider and savings.

(d) Gross submitted charge amounts, amounts determined to be ineligible, amounts applied to deductible, copayments and coinsurance, and amounts adjusted for COB.

(e) Hospital admissions, average charge approved per day, average lengths of stay.

(f) Claims paid by type of service category showing total number of claims, eligible charges and claim payments for each category.

(g) Inpatient discharges, bed days, charges and payments by major diagnostic category.

(h) Turnaround times on COB claims, non-COB claims and total claims.

(i) High amount claimant reports.

(j) A claims lag report.

76. Describe any other claim/management reports you would be able to supply to the plan sponsor regularly at no additional charge and the frequency with which the reports could be provided.

77. Describe any other kinds of management information reports (content and frequency) that are available.

78. How will your data system link with the State's automated data eligibility system?

79. Describe your computer system security measures. Describe the system backup and disaster recovery procedures for your medical claims and network systems. How often are the systems tested? When were the systems last tested and what were the results? What system down time have you experienced over the latest 12 months? How long are records maintained?

80. Provide a statement regarding your company's Y2K compliance status. Include specific descriptions of any system issues that could affect the State's benefits and payroll systems. Do you warrant the services and software used by your firm to properly function during the transition to the Year 2000?

81. Describe the nature of your POS network structure and provide an organizational chart of your organization. Are any key personnel including officers, medical directors and board members, affiliated with any hospital, physician medical association, or other provider interest?

82. How long has the network been operational (by area)?

83. Describe how network providers identify plan participants who are eligible for network benefits.

84. Do you require members to select a Primary Care Physician? Do primary care physicians act as gatekeepers for specialists' service and hospitalizations? Describe the referral process. In choosing a PCP:

a. Does the whole family have to pick the same medical group/individual physician?

__ Yes __ No

b. Is there a limit on the number of changes allowed per year?

__ Yes __ No

85. Do primary care physicians assist in arranging for services such as: home health care, hospice, skilled nursing, convalescent facilities, durable medical equipment and mental health/chemical dependency. Please explain.

86. Can OB/GYNs, pediatricians, others be selected as primary care physicians (PCP)? How long are PCP referrals valid (one specialty visit, duration of illness/treatment)?

87. Complete the following table:

Access Criteria	Primary Care Physicians	Specialists
Average number of office hours available to participants		
Percent of Providers with evening or weekend office hours		
Average number of days between request for appointment and actual visit		

88. Provide the annual turnover rate for Primary Care Physicians and specialists in your network for the latest two years. Describe the methodology used to calculate these turnover rates.

89. Do the participating hospital agreements include hospital-based physicians (including radiologists, pathologists, anesthesiologists, emergency room physicians, etc.)? Please explain.

90. Do your physician and hospital contracts have a "continuation of care" clause that says if a physician or hospital cancels or fails to renew their contract, that care which began with a network provider will continue to be provided and reimbursed as a network provider?

__ Yes __ No

91. To enable the State of Maryland to accurately compare the accessibility of each respondent's managed care networks, it is critical that the analysis you provide meets the following data standards and report specifications.

a. **Data Standards**

i. Use the employee data file on the enclosed diskette.

ii. Your network physician addresses should be exactly geocoded. For any address that cannot be exactly geocoded, the address should be geocoded using a technique which takes into account population density. Placing physicians at zip code centroids or randomly within zip codes is not acceptable.

iii. If more than one physician is located at the same address, all physicians at that address should have the same geographic coordinates.

iv. The analysis should include only physicians with open practices.

v. Physicians should be classified based on their primary specialty only. For example, a pediatric cardiologist should be classified a cardiologist not a pediatrician.

vi. Physicians with two or more office locations should only be counted once, based on their primary office location.

b. **Report Specifications**

i. To ensure quality and consistency, we are requesting that you use the GeoNetworksJ managed care accessibility analysis system.

ii. Prepare an accessibility analysis for each of the following provider groups with a defined Employee group of "All Members", regardless of geographic area. There will be 12 separate analyses (four provider types in each of the defined access standards.

1. Provider Groups

Physician Group	Primary Care Specialties
Adult Medicine	Family Practice General Practice Internal Medicine
OB/GYN	Gynecology Obstetrics
Pediatrics	Pediatrics

Hospital Group	Hospital Type
Acute Care Hospitals	Acute Care

iii. Access standards

Mileage should be calculated on an estimated driving distancebasis.

Access Standard			
Number of Physicians	**Miles**	**Number of Hospitals**	**Miles**
2	5	1	5
2	8	1	10
2	20	1	20

iv. Each of the 12 analyses should consist of the following pages:

(1) A Summary Page for those employees who do not have the desired access.

2. A map showing the location of all employees included in the analysis.

3. A map showing the location of all physicians/hospitals included in the analysis.

4. A map showing the location of the employees who do not have the desired access.

5. A chart indicating the percentage of employees having access to one, two and three providers for various distances.

6. A list containing the following information sorted by county, city and zip code:

   (1) County
   (2) City
   (3) Zip Code
   (4) Number of employees in zip code
   (5) Number of employees without the desired access
   (6) Percentage for employees without the desired access
   (7) Average distance to the closest, second closest and third closest physicians/hospitals

7. A map representing the geographic area that is covered by your plan, which should include labels of the following:

   (1) County boundaries
   (2) Interstates

v. Save to an Access file the data behind the analysis in "6" above and submit it a 32 diskette along with your response.

92. How is medical necessity defined? What procedures are currently considered experimental by your organization. How are conflicts regarding experimental treatment and testing adjudicated?

93. What conditions are considered eligible for emergency care in non-network facilities? Describe the procedure in place for covering emergency care services performed by non-network facilities?

94. Describe the coverage portability for members who temporarily reside or permanently transfer to non-network service areas.

95. Describe how treatment in progress is covered during the initial transition.

96. Describe any benefit extensions that you offer in addition to those described above.

97. Does your organization offer any special programs to arrange for home health care or rehabilitation, hospice care, skilled nursing care, allied health practitioners, health fitness promotion, health assessment/appraisal or child care for sick children? If so, describe each program.

98. Indicate whether any of the services listed below are provided through your network in the State of Maryland.

	Services Provided through Network	Services Not Provided through Network	# of Maryland Facilities Providing Service
Alcohol/chemical dependency			
Ambulatory surgery			
Blood bank			
Cardiac care unit			
Cardiac catheterization			
CT scanner			
Diagnostic radioisotope facility			
Emergency room			
Hemodialysis			
Hospice			
Intensive care unit			
Megavoltage radiation therapy			
Neonatal intensive care			
Occupational therapy			
Open heart surgery			
Pediatric inpatient services			
Physical therapy services			
Psychiatric services			
Rehabilitation outpatient			
Respiratory therapy			

	Services Provided through Network	Services Not Provided through Network	# of Maryland Facilities Providing Service
Skilled nursing home services			
Speech therapy			
Therapeutic radioisotope facility			
Ultrasound			
Burn care unit			
Extracorporeal shock wave lithotripter			
Nuclear magnetic resonance (MRI)			
Organ transplants (3 most frequent) - heart - liver - kidney			
Rehabilitation inpatient services			
Trauma center (level I or II)			

If these services are not available in the network, can they be provided to members through arrangement with non-affiliated hospitals?

99. Complete the following Physician Reimbursement table:

Check All That Apply	Primary Care Physicians	Network Specialists	Non-Network Physicians (POS)
A) Predominant Reimbursement Method			

Check All That Apply	Primary Care Physicians	Network Specialists	Non-Network Physicians (POS)
! Fee for Service			
! Discounted Fee For Service			
! Capitation			
! Salary			
! Risk Sharing			
! Other (Describe)			
B) Source of Fee Schedule			
! HIAA			
! In-House			
! Medicare			
! Other (Describe)			
C) Frequency of Reimbursement Update			
! Semi-Annual			
! Annual			
! Other (Describe)			
D) Risk Sharing			
! Bonus Pool (Y/N)			
! Withholds (Y/N)			

Check All That Apply	Primary Care Physicians	Network Specialists	Non-Network Physicians (POS)
! Retroactive Payments (Y/N)			

100. If providers are capitated, describe how capitation rates and salaries are developed. List all services and/or types of providers covered by the capitation payments. Include any minimum earnings requirements.

101. Are there financial incentives or disincentives to network providers that are tied to utilization goals, specialty referrals, quality of care outcomes or other performance results. If so, please explain. Describe Risk Sharing arrangements.

102. Can a plan sponsor provide its own set of allowances or "freeze" the existing level of reimbursement? If so, is there any limitation on, or is there any extra charge for doing so? If so, what are the limitations/charges?

103. Will R&C data and claim payment data be made available by CPT code and zip code? Can a claimant find out about the maximum allowance for a specific procedure in advance of having the procedure done? If so, explain.

104. Under what situations will you reimburse assistant surgeons? How do you determine situations that warrant assistant surgeon reimbursement? Do you reimburse the assistant surgeon a percentage of the surgical allowance for the specific surgery performed? What percentage do you use? If you use another method of reimbursement, explain.

105. How do you reimburse multiple surgical procedures being performed during one operation? Is a sliding scale used for the 1st and subsequent procedures?

106. Do you prohibit network physicians from being direct owners, or have any financial involvement, of outpatient facilities such as labs, surgicenters and imaging centers? If not, is there any monitoring of self-referrals to physician owned outpatient facilities?

107. What steps are taken if the maximum allowable charge is exceeded? How are the plan sponsor and plan participants supported in their resistance to charges in excess of allowances? Do your provider contracts prohibit providers from balance billing patients above the network allowance?

108. When you are the secondary payor in a COB situation, do you use your UCR profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?

109. What are your average R&C savings and how are they calculated?

110. Describe how network hospitals are reimbursed. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor.

111. Are your financial incentives for network hospitals tied to utilization goals, readmission rates, quality of care outcomes or other performance results? If so, please explain.

112. Are illnesses/conditions and services associated with your Centers of Excellence programs bundled with regard to reimbursement? Is the facility at risk for cost incurred in excess of the negotiated charge?

113. How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed? Are they reimbursed on a discounted fee arrangement, bulk-billing arrangement, or capitated arrangement? If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.

114. Describe any other contractual relationships with any other providers such as physical therapists, orthotics suppliers, prosthetic suppliers, eye care and home health care providers.

115. When participant coinsurance exists for discounted plans, are providers obligated to limit their charge to participant's to the coinsurance percentage of the **discounted charge**?

116. Complete the following grid with respect to your organization=s accreditation status. *Check all of the types of accreditation that apply to your organization.*

Type of Accreditation	Current Level of Accreditation	Duration of Continuous Accreditation (# of years)
G None		
1. G American Accreditation Health Care Commission Inc. (AAHCC) formerly known as URAC.	*Check one:* G Full accreditation. G Denied/non-accredited. G Pending (initial certification requested but not yet finalized). G Not yet requested.	G Less than 1 year. G 1 year. G More than 1 year, but less than 2 years. G 2 years. G More than 2 years, but less than 3 years. G 3 years or greater.
2. G JCAHO	*Check one*: G Accreditation with commendation. G Accreditation. G Accreditation with recommendation for improvement. G Conditional accreditation. G Provisional accreditation. G Preliminary non-accreditation. G Denied/non-accredited. G Pending (initial visit requested but not yet visited). G Not yet requested.	G Less than 1 year. G 1 year. G More than 1 year, but less than 2 years. G 2 years. G More than 2 years, but less than 3 years. G 3 years or greater.
3. G NCQA	*Check one*: G Full (3 years). G One Year. G Provisional. G Denied/non-accredited. G Pending (initial visit requested but not yet visited). G Not yet requested.	G Less than 1 year. G 1 year. G More than 1 year, but less than 2 years. G 2 years. G More than 2 years, but less than 3 years. G 3 years or greater.
4. G Other (List)	_____ _____ _____ _____	G Less than 1 year. G 1 year. G More than 1 year, but less than 2 years. G 2 years. G More than 2 years, but less than 3 years. G 3 years or greater.

117. For the purpose of this question, the term ACenter of Excellence@ means a facility screened and selected by your organization in a process above and beyond your usual credentialing program. It also means the facility has been designated as one of your organization's Centers of Excellence due to their clinical expertise in a particular health field and its agreement to bill according to financially acceptable arrangements.

A. Indicate which Centers of Excellence programs your organization **currently** has designated as part of your network. *Check all that apply*.

G No designated Center of Excellence currently in our network.
G Organ transplant.
G Tissue transplant (bone marrow).
G Cancer
G Cardiac
G Other (specify)_____

B. List the "Centers of Excellence" facilities by name and region. Do you send patients outside of their community for special care when similar care is available locally Indicate any other formal Centers of Excellence with which your organization has contracted in addition to those checked in A. above.

C. Assuming the enrollee is covered, what types of human organs or tissue transplants are covered? *Check all that apply*.

G Heart
G Kidney-Pancreas
G Cornea

- Heart Lung
- Kidney

- G Intestine
- G Lung
- G Bone Marrow
- G Liver
- G Pancreas
- G Other (specify)_____

118. Complete the following grid regarding your organization's FORMAL disease management program. *Check all that apply*. For the purpose of this question, Adisease management@ will refer to a **formal** program designed to improve the health, compliance and quality of life of enrollees, as well as to lower costs through a systematic approach to actively managing a population of enrollees with a specific disease. **It does not mean that your organization tracks data for HEDIS reporting purposes.**

Indicate Programs Currently in Place	# of Years Program In Place	# of Enrollees Currently Participating	Program Performed by: [1] In-House Personnel or [2] Outsourced (*e.g.* drug company)
G None at present			
G Adult-onset diabetes			
G Hypertension			
G Pediatric asthma			
G Juvenile diabetes			
G Epilepsy			
G Rheumatoid arthritis			
G Chronic obstructive pulmonary disease)			
G Osteoarthritis			
G Tuberculosis			
G Adult asthma			
G Migraine headache			
G Chronic renal failure			
G Peptic ulcers			
G Major depression			
G Hemophilia			
G Heart failure			
G Other: _____ _____			

119. How often does your organization conduct general enrollee satisfaction surveys? *Check only one.*

120. What characteristics listed below describe your **MOST COMMONLY USED** enrollee satisfaction survey tool? *Check only one.* **(Provide a copy of your survey tool).**

G a. Use the NCQA member health care survey instrument.

G b. In-house (proprietary) instrument.

G c. Other nationally used instrument. Indicate name: _____

G d. Other: _____

121. For the past year, what percentage of enrollees responded that they were at least Asatisfied@ with your organization?

122. What is the scope of enrollees who are typically included in your enrollee satisfaction survey?

123. What is your **average** rate of response to satisfaction surveys?

124. What percentage of newborns, born to mothers enrolled in your plan, receive their first dose of hepatitis B vaccine **before** leaving the hospital?

125. Check the **pediatric** subspecialties typically participating, as **contracted** providers, in your Maryland networks. *Check all that apply.*

G Oncologist

G Endocrinologist

G Nephrologist

G Gastroenterologist

G Pulmonologist

G Hematologist

G Cardiac Surgeon

G. Neurologist

G Psychiatrist

G Cardiologist

G Orthopedics

G General Surgeon

G Urologist

G Neurosurgeon

G Other: _____

126. **How** does your organization encourage parents to bring their children in for proper immunizations? *Check all that apply.*

G We do not specifically promote this wellness service.

G Verbal encouragement to the parents is the responsibility of the physician.

G It is the responsibility of the parents to schedule immunizations at their desire.

G **Reminder card/notice** sent to parents by **provider's office** at the appropriate intervals.

G **Reminder phone call** placed to parents by **provider's office** at the appropriate intervals.

G **Reminder card/notice** sent to parents by **our organization** at the appropriate intervals.

G **Reminder phone call** placed to parents by **our organization** at the appropriate intervals.

G Other:_____

127. The National Institute of Health has classified the following services as Alternative Medicine practices. These practices are currently under NIH investigation to determine efficacy. Indicate whether any of the following services, when requested by enrollees are commonly considered eligible expenses by your organization. *Check all that apply.*

G Homeopathic services
G Naturopathic services
G Biofeedback
G Herbal medicine
G Chiropractic/spinal manipulation
G Acupuncture
G Acupressure
G Yoga
G Therapeutic massage
G Rolfing
G Trager/Feldenkrais manual healing techniques
G Ayurvedic medicine
G Nutritional therapy: macrobiotics, megavitamin
G Other: _____

128. Indicate your plan's usual coverage for self-referred care, **without prior permission from the PCP**. *Check all that apply.*

G No coverage.
G Annual OB/GYN services from an **in**-network provider.

- Annual OB/GYN services from a **non**-network provider.
- Emergency care.

G Certain **physician specialists**. (List:_____)

G Can use any network provider without prior permission from a PCP.

G Other: _____

129. How does your organization **routinely educate providers** regarding your organization's policies and procedures? *Check all that apply.*

G Provide a manual.

G. Regularly send a newsletter.

G Make periodic office visits.

G Hold special meetings.

G None of the above.

G Other: _____

130. Does **your organization perform visits to physician offices**? Do you visit both the PCPs and specialists? On what frequency?

131. List the **top five most common complaints** by your network providers.

132. Does your organization provide Category 1 accredited Continuing Medical Education (CME) meetings for physicians in your network?

133. Indicate the type of **formal**, professional rehabilitation services available from your organization. *Check all that apply.* For the purpose of the following questions, Arehabilitation@ refers to a process of treatment and education that leads a disabled enrollee to attainment of maximum function and independence.

G No rehab providers under contract or part of our organization.

- G Cardiac
- G Speech
- G Pulmonary
- G Physical
- G Occupational
- G Other: _____

134. For which of the following rehabilitation services are discount financial arrangements **currently** in place in the State of Maryand? *Check all that apply.*

- G Inpatient physical rehabilitation facilities.
- G Durable medical equipment vendors (*e.g.*, for beds, ventilator, apnea monitor).
- G Outpatient physical therapy (PT) providers.
- G Corrective appliance vendors for prosthetic devices (*e.g.*, artificial arm, leg).
- G Outpatient occupational therapy (OT) providers.
- G Social services personnel (to assist with financial aid, filing of Social Security benefits, etc.).
- G Outpatient speech therapy providers.
- G Outpatient pulmonary rehab program.
- G Providers to perform neuropsychological testing.
- G Outpatient cardiac rehab program.

135. Check only those wellness services which your organization **currently** offers to enrollees. (Do not include services which may be provided if an enrollee schedules an illness-related office visit with a provider of your network.) *Check all that apply.*

- G None
- G Wellness physical exam
- G Vision screening
- G Body fat testing
- G Health risk profile/survey
- G Health fair
- G CPR training
- G Hearing screening
- G Nutrition education
- G Fitness testing
- G Pneumococcal vaccine
- G Weight control
- G Influenza vaccine
- G Stress management
- G Adult tetanus booster
- G Smoking cessation
- G PSA test
- G Lab testing for smoking (*e.g.*, carbon monoxide, cotinine)
- G Cholesterol screening
- G Substance abuse screening
- G Hypertension screening
- G Back care
- G Glaucoma screening
- G Exercise classes
- G Colon cancer screening
- G Other: _____

136. In order for your proposal to be considered or accepted, the only compensation to be

received by or on behalf of your organization in connection with this Plan shall be that which is paid directly by the Plan. Will you comply with these conditions as stated herein?

137. Submit a copy of your proposed standard form of agreement for provision of administrative services.

138. The State wishes to include a clause to the effect that, upon contract termination, the cost of any work required by a new administrator to bring records in unsatisfactory condition up to date shall be the obligation of your firm and such expenses shall be reimbursed by your firm. Do you agree to this provision?

139. Will you provide the plan sponsor the right to audit the performance of the plan and services provided? Indicate what services, records and access will be made available to the plan sponsor at no additional charge. Also indicate frequency and notice requirements that are part of the right to audit provision.

140. Would you transfer enrollment cards, claim information and other administrative records to any carrier/TPA who replaced you at no charge? Indicate how you will convert existing claim records and time requirements for this conversion.

141. Will you agree to pay run out claims if your agreement is cancelled? For how long?

142. Do you agree that all books, records, lists or names, plates, seals, passbooks, journals and ledgers and all data specific to this Plan shall be the property of and shall be used exclusively for this Plan at the direction of The State of Maryland?

143. Confirm that your proposal, and plan design offered, is in compliance with all federal and state laws and regulations that pertain to employee benefit programs, relevant state insurance regulations and other related laws.

144. Explain the methodology and data to be used for the renewal process.

145. Indicate what procedure your company requires when an employee desires to elect coverage after the period during which he was originally eligible (i.e., how is a late entrant treated)? Discuss any medical evidence requirements for health coverage.

146. Describe when premium is due, grace periods, and the process for accessing late payment charges? Include the interest rate credited to early payment, and interest rate charged for late payments.

147. Describe the way in which the banking arrangement works. Include explanations of the nature of the account from which claims are paid (e.g., in whose name it appears, where it will be, the timing of the call for funds (e.g., as checks are issued, as they are cashed), any deposit amount required in the account, its term (weekly, monthly) how it is determined and any interest earned on the deposit, or on amounts held in the account until checks are cashed. How quickly and often must the plan sponsor make reimbursements to you?

148. Explain how excess deposits are handled during the term of the plan and when deposits are returned upon plan termination

149. If your plan does not require the use of a special bank account but rather calls for funds on a single monthly bill, please explain the timing of such bill, when payment is due, the definition of claims due (checks issued or cashed) and what interest charges are made (or credits foregone) on such a program, relative to a conventionally insured plan.

150. How often are check registers and reconciliations furnished? What information is contained in these reports? (Please provide a sample.)

151. Do you stockpile claims to a certain level before releasing them?

152. The State intends to pay the lesser of the maximum quoted rate or the actual capitation

payments to providers. Explain how you will provide and identify actual monthly capitated provider reimbursements as part of your billing to the State.

153. What audits of reconciliations are done?

154. Do you verify bank transfers as they occur?

155. Provide a detailed implementation plan that clearly demonstrates the offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on January 1, 2000. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (January 1, 2000). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. A detailed organizational chart as well as resumes should be included.

156. Provide a detailed management plan that clearly demonstrates the offeror's ability to manage this program on an ongoing basis.

a. The management plan should include the name, title and resume of the person with overall responsibility for planning, supervising, and performing account support services for the State. The management plan should also note what other duties, if any, this person has and the percentage of this person's time that will be devoted to the State.

b. The management plan should also include an organizational chart identifying the names, functions, and reporting relationships of key people directly responsible for account support services to the State. It should also document how many account executives

and group services representatives will work full-time on the State's account, and how many will work part-time on the State's account.

c. The management plan should describe account management support, including the number of meetings to be held with the State annually, information to be reviewed at each meeting, frequency of ongoing communications, and assurance of accountability for account services satisfaction. It should identify the location of all service centers that will be used to service this contract. It should also include the mechanisms and processes in place to allow Employee Benefits Division personnel to communicate with account service representatives; the hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The Employee Benefits Division requires identification of an account services manager to respond to inquiries and problems, and a description of how the offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and a description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract.

157. List any additional or optional services that you offer that have not been requested.

158. Describe the benefits that will accrue to the Maryland economy as a direct or indirect result of your performance of this contract:

a. the amount or percentage of contract dollars to be recycled into Maryland's economy in support of the contract through the use of Maryland subcontractors, Maryland suppliers, MBEs, and Maryland joint venture partners. Be as specific as possible. Provide a breakdown of expenditures in this category.

b. the number and type of jobs for Maryland residents resulting from this contract.

Indicate job classifications, number of employees in each classification, and the aggregate payroll to which you commit at both prime and, if applicable, subcontract levels.

c. tax revenues to be generated for Maryland and its political subdivisions as a result of this contract. Indicate tax category (sales tax, payroll tax, inventory tax, and estimated personal income tax for new employees).

d. other benefits to the Maryland economy, which you promise will result from the award of this contract. Please describe the benefit, its value to the Maryland economy, and how it will result from the contract award.

SECTION 4. EVALUATION CRITERIA AND SELECTION PROCEDURE

4.1 EVALUATION CRITERIA

Evaluation of the proposals will be based on the criteria set forth below and developed from both the technical proposal and financial proposal. In evaluating the proposals, technical and merit will have greater weight than financial.

In evaluating proposals, the State=s first priority is to maintain sufficient POS coverage across all geographic areas of the State, including meeting special geographic coverage needs.

Criteria for evaluation of the technical proposals are listed in descending order of importance.

1. Organization
    a. History and Structure
    b. Experience
    c. Past performance on similar contracts

2. Administration
    a. Program administration
    b. Member Services
    c. Claims paying services
    d. Utilization management
    e. Information services and data reporting

3. Networks
    a. Structure and services
    b. Coverge of eligible participants
    c. Provider reimbursement

4. Quality
    a. Centers of Excellence
    b. Disease management
    c. Enroll satisfaction
    d. Quality management

5. Contracts and Funding
6. Implementation and Account Management
7. Maryland Economic Impact

4.2 SELECTION PROCEDURE

The contract will be awarded in accordance with the competitive sealed proposal process under Code of Maryland Regulations 21.05.03. The competitive sealed proposals method is based on discussions and revision of proposals during these discussions.

Accordingly, the State may hold discussions with all offerors judged reasonably susceptible of being selected for award, or potentially so. However, the State also reserves the right to make an award without holding discussions. In either case of holding discussions or not doing so, the State may determine an offeror to be not responsible and/or not reasonably susceptible of being selected for award, at any time after the initial closing date for receipt of proposals. Financial proposals of qualified offerors will be opened only after all technical proposals have been evaluated.

After a review of the financial proposals of qualified offerors, the Procurement Officer may again conduct discussions with the offerors. The purpose of any such discussions will be: to assure full understanding of the State=s requirements and the offeror=s ability to perform; to obtain the best price for the State; and to facilitate arrival at a contract that will be most advantageous to the State.

Offerors must confirm in writing any substantive oral clarification of their proposals made in the course of discussions. When in the best interest of the State, the Procurement Officer may permit offerors who have submitted acceptable proposals to revise their initial proposals and submit in writing best and final offers.

Upon completion of all discussions and negotiations, reference checks, and site visits, if any, the Procurement Officer will recommend award of the contract to the responsible

offeror whose proposal is determined to be the most advantageous to the State, considering price and the evaluation factors set forth in this RFP. In making this determiniation, technical merit will receive greater weight than price.

SECTION 5. PROPOSAL FORMAT

5.1 GENERAL

The proposal should address all points and questions outlined in the RFP. It should be clear and precise in response to the information and requirements describd in the RFP.

5.2 FORMAT OF THE PROPOSAL

Proposals must be submitted in TWO SEPARATE VOLUMES, TECHNICAL AND FINANCIAL. Technical volumes must be sealed separately from financial volumes but submitted simultaneously at the Issuing Office. An original, so identified, and ten (10) copies of each volume are to be submitted.

Each offeror is required to submit a separate sealed package for each volume which is to be labeled ATechnical Proposal@ and AFinancial Proposal@ (respectively). Each sealed package must bear the RFP title, name and address of the offeror, the volume number (I or II), and the closing date and time for receipt of the proposal on the outside of the package. A transmittal letter and a statement acknowledging receipt of any and all addenda should accompany the technical proposal. The sole purpose of this letter is to transmit the proposal; it should be brief and signed by an individual who is authorized to commit the offeror to the services and requirements as stated in the RFP. All proposals must be page numbered from beginning to end. Enclosed in each package should be the original and ten (10) copies of the offeror=s proposal.

5.2.1 Volume I - Technical Proposal

The Technical Proposal shall include:

a. Executive Summary

The offeror shall condense and highlight the contents of the Technical Proposal in a separate section titled AExecutive Summary.@ The summary shall provide a broad overview of the contents of the entire proposal and explain any deviations.

b. Offeror Qualifications

Provide a detailed discussion of the Offeror=s service capabilities and approaches to address the qualifications outlined in Section 2 of this RFP. Fully explain how the proposed services will satisfy the requirements of the RFP.

c. Completed Questionnaire

Repeat each number and question as provided in Section 3.6. Provide clear and complete responses. To assist offerors in the preparation of their responses, a disk copy of this questionnaire in Wordperfect 6.1 format is available.

d. Required Submissions

Offerors must submit:

1. Completed Proposal Affidavit (Attachment B - original copy only)
2. Certified Minority Business Enterprise (MBE) Affidavit (See Section 1.17 and Attachment D-1).
3. Financial Statements and Annual Reports, (audited preferred).

e. Subcontractors

Offerors must identify subcontractors and the role these subcontractors will have in the performance of the contract. Disclosure of MBE subcontractors at this point is optional.

5.2.2 Volume II - Financial Proposal

Under separate sealed cover from the Technical Proposal and clearly identified with the same information noted on the Technical Proposal, the Contractor must submit an original and ten (10) copies of the Financial Proposal. The Financial Proposal must contain all cost information in the format specified in Attachment H of this RFP. The cost that will be compared among offerors will be the total of costs A.6. and B. On page 2 of Attachment, Exhibit 1 of the financial proposal.

ATTACHMENTS

In accordance with State Procurement Regulations, the Proposal Affidavit, **Attachment B**, and Certified MBE Utilization and Fair Solicitation Affidavit, **Attachment D-1**, must be completed and submitted with the Technical Proposal, and the Contract Affidavit, **Attachment C**, must be submitted at Contract award.